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AGENDA ITEM

☒ For Possible Action
☐ Information Only

Date: May 20, 2014
Item Number: III
Title: Exchange Move Forward Options

PURPOSE

The purpose of this report is to provide the Board with options moving forward to meet the requirements of the Affordable Care Act.

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BACKGROUND

[Section 1311](#) of the Affordable Care Act (ACA) requires that each state shall establish an American Health Benefit Exchange for the state that facilitates the purchase of qualified health plans, provides for the establishment of a Small Business Health Options Program (SHOP), and informs individuals of eligibility for federal subsidies (Advanced Premium Tax Credits and Cost Sharing Reductions) and public assistance programs (Medicaid and CHIP).

Nevada established the Silver State Health Insurance Exchange (Exchange) in 2011 through [NRS 695I](#) to meet the requirements of a State Based Exchange. Additionally in 2013, Nevada expanded Medicaid to individuals whose household income falls between 100% and 138% of the Federal Poverty Level (FPL).

On March 26, 2012, the Exchange released [RFP 2023](#) to solicit proposals to provide a Business Operations Solution (BOS) to support the information technology and business functions of the Exchange in order to begin enrolling people in health insurance coverage by October 1, 2013. The Exchange awarded Xerox State Healthcare, LLC (Xerox) a [contract](#) in the amount of \$71,963,299 approved by the Board of Examiners on August 14, 2012 to develop the BOS and implement a Customer Contact Center. Since then, the contract has been amended three times:

- [Amendment 1](#): Revise Deliverable Payment Schedule to remove TBD statements and replace with actual dates; revise the estimated population of potential Exchange members; and to extend the hours of the Call Center to meet demand. (Approved April 23, 2013)
- [Amendment 2](#): Revise the overall contract amount to \$75,465,151 increasing the original contract by \$3,501,852 to support various change order requests required to meet evolving federal requirements. (Approved September 10, 2013)
- [Amendment 3](#): Revise deliverable dates for specific deliverables and to revise the RFP response by Xerox to allow certain work to be performed outside of the United States. (Approved November 27, 2013)

Nevada Health Link (Exchange's forward facing consumer name) went live on October 1, 2013 as mandated by the ACA, and individuals, families, and employers began utilizing the web portal and call center. Initial issues surfaced with the Exchange and created barriers to enrollment and continued operation. The Exchange experienced:

1. Problems early in the project development. Unbeknownst to Exchange staff, the proposed web portal platform was abandoned due to too many modifications needed and a complete new platform was designed from the ground up
2. Extensive and reoccurring errors navigating the system requiring multiple start overs
3. Extremely long wait times at the call center
4. Inaccurate eligibility decisions
5. A lack of or inaccurate display of health plans and subsidies
6. An inability to finalize payments for selected plans utilizing any method
7. An inability to accurately report enrollment, utilization, producer activity, etc.

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8. Complete abandonment of the broker/assister portal
9. Incomplete design for redeterminations, terminations, and qualifying life events
10. Incomplete Electronic Data Interchange (EDI) file processing between the BOS and insurance carriers
11. A inability to effectuate enrollments automatically requiring manual workarounds
12. Incomplete and inaccurate testing and pre-production environment
13. Numerous bugs and glitches

Nevada Health Link underperformed during open enrollment and Exchange staff internally revised the projected enrollment in a Qualified Health Plan from 118,000 down to 50,000. As of March 31, 2014 (last day of open enrollment), Nevada Health Link was able to enroll 25,899 individuals in a qualified health plan.

On March 6, 2014, the Board approved the contract for Deloitte to perform an assessment of the Xerox BOS. The purpose of the assessment was to assess the current state of the Exchange functionality, supporting processes, and technologies. Deloitte was to identify strengths, gaps, and issues, and provide remediation options. On April 10, 2014, Deloitte presented to the Board the [Nevada SSHIX Assessment](#) results.

On March 20, 2014, the Board approved a special enrollment period to assist Nevadans who had technical issues enrolling during open enrollment. The period began April 1, 2014 and is scheduled to end May 30, 2014. As of May 10, 2014, Nevada Health Link has enrolled 35,034 individuals in a qualified health plan.

Due to reports of continued issues with effectuating enrollment and processing individual premium payments, on March 27, 2014, the Board decided to remove individual billing from Xerox and place it with the individual insurance carriers for an undecided date of implementation. A plan of action is currently being developed with an initial date of transfer just prior to open enrollment (November 15, 2014) for a plan year 2015 implementation.

On April 17, 2014, Bob Carr and Associates, the contractor hired to perform a BOS Audit for the period of October 1, 2013 through February 28, 2014 presented their [Service Level Agreement Audit Report](#) to the Board. That report outlined numerous areas where Xerox was failing to meet contract requirements.

On May 8, 2014, the Board requested Exchange staff to develop and evaluate options for the Board to review to ensure the Exchange moves forward appropriately and effectively and as required by Federal Law.

CMS SUPPORT

As part of the fact finding process, Exchange staff, the Board Chair, DOI, and a representative from the Governor's Office met with CMS personnel on May 15 in Washington DC to discuss potential options and levels of support. Our federal partners provided several options in addition to those provided by the Assessment.

The consistent message throughout the day was of support for Nevada's Exchange Board to decide the direction of the exchange, and the desire to provide an accurate, accessible and sustainable marketplace for Nevada. Administrator Tavenner stated she would support the method of choice decided by the Board. CMS discussed the possibility of Nevada becoming a Supported State Based Marketplace. This is different than joining the Federally Facilitated Marketplace, and slightly different than operating a unique State Based Marketplace. For purposes of this discussion, the three designations are defined here:

- **State Based Marketplace (SBM):** An SBM is a state controlled marketplace where all facets of the exchange are developed, managed, and controlled by the state. The state is responsible for eligibility for Qualified Health Plans (QHPs) in the Individual market and SHOP, Medicaid/CHIP, and federal subsidies. Additionally, the state is responsible for enrollment in QHPs and Medicaid/CHIP, as well as outreach and education and a Navigator program. The state is required to maintain a web site and a call center for customer support.
- **Supported State Based Marketplace (SSBM):** An SSBM is very similar to the SBM; however, CMS will provide the eligibility and enrollment piece for both Individual and SHOP marketplaces, as well as the web site and call center functionality. A state will still be required to have an entry point for Medicaid/CHIP consumers (by phone, website, and paper application), as well as Medicaid customer support (call center). In this model, CMS would be acting very similarly to our own current BOS vendor. A state will retain its "State Based Marketplace" designation.
- **Federally Facilitated Marketplace (FFM):** An FFM is a federally managed marketplace where states have opted to defer all control to the feds. Limited state support may continue (plan certification and rate review by a state's Insurance Division), but all ACA requirements for an Exchange will be under the direct responsibility of the federal government. A state cannot be called an SBM if the FFM model is chosen.

To summarize, CMS is willing to support Nevada as a Supported State Based Marketplace with an opportunity to utilize the federal eligibility and enrollment system for plan year 2015 (or beyond). This can allow Nevada the opportunity to make an informed and thoughtful decision regarding the future of the Exchange. This process, where applicable, will be discussed in the options below.

The process to utilize the federal eligibility and enrollment system would require significant work on behalf of Medicaid to implement the account transfer capabilities by November 15, 2014. In this model, the state Medicaid agency is still responsible for eligibility and enrollment for Medicaid and CHIP, with nearly all of the same required functionality as in an SBM model in addition to two new Federal hub services. The costs associated with Medicaid upgrades would require state general fund match (90% federal, 10% general fund match). Additionally, the use of the federal system would mean that the current Call Center would not have access to the Federal system and therefore may not be needed in its current capacity. However, a toll-free number and the ability to accept and process phone and mailed paper applications would remain a Nevada Medicaid responsibility per the ACA. These issues would need to be addressed quickly and

cohesively with the Division of Welfare and Supportive Services (DWSS). Preliminary questions have been posed to DWSS and their contractor, and they agree the process can be met if the funding is available.

DEVELOPMENT OF OPTIONS

Exchange staff utilized the following process to develop the options:

1. Reviewed the Deloitte Assessment
2. Reviewed the Health Claim Auditors, Inc.'s Audit Report
3. Consulted with other states in a similar situations (Oregon, Maryland, Arizona, Florida)
4. Conducted meetings with staff from the Division of Insurance (DOI), Division of Welfare and Supportive Services (DWSS) and Enterprise Information Technology Services (EITS), and the Governor's Office
5. Traveled to Washington D.C. and discussed all options with Centers for Medicaid and Medicare Services (CMS) administration and technical staff

OPTION 1: REMEDIATE XEROX AND CONTINUE WITH ITS SYSTEM

This option moves forward with Xerox as the Exchange's web portal vendor as per the current contract that expires December 31, 2016 (with the option for three, one-year extensions). Xerox would continue to utilize its BOS platform, as well as maintain the Customer Contact Center. The Individual marketplace would follow all current policies (with the exception of individual billing), and the SHOP marketplace would continue to be supported. Plan Certification would remain with the Division of Insurance, and plan offerings would continue that include standalone dental plans. All outstanding contract deliverables would be required, and the system would need to be stable and completely functional.

OPTION 1A: REMEDIATION BY NOVEMBER 15, 2014 - UTILIZE A THIRD-PARTY COMPANY AS A PROJECT MANAGEMENT OFFICE (PMO)

Description

Similarly to Minnesota, the Exchange can contract with a third-party vendor to provide project oversight and management. Minnesota recently announced (April 16, 2014) that they have contracted with Deloitte Consulting to advise agency leaders on how much of the current system can be salvaged for the future and to make the site operate as well as it can currently. Deloitte will bear ultimate responsibility for ensuring MNsure meets deadlines, stays within budget, and meets quality benchmarks. MNsure will pay Deloitte \$4.95 million out of MNsure's 2014 budget of federal funds. This initial funding; however, may not be the final contract price as Deloitte is currently performing an assessment of MNsure and if additional issues are discovered may go back to change the contract to meet Minnesota's needs.

Federal Contingency

If this option is chosen by the Board, the Exchange and Xerox will create a corrective action plan with detailed thresholds of performance and a schedule of deliverables through June 30, 2014. Should Xerox prove unable to meet these immediate goals, the Exchange can choose to utilize

the Federal infrastructure for Eligibility and Enrollment for plan year 2015 and become a Supported State Based Marketplace. Calendar year 2015 could then be used by Xerox to fully remediate its system to be ready for the open enrollment starting October 15, 2015.

Feasibility

The Exchange can move forward with this option rather easily. Xerox is under contract, and the funds needed to acquire a third party PMO are available with current grant awards. Should the Board wish to pursue this option, a streamlined RFP process could be utilized to procure a contract within the requirements of the Nevada State Purchasing Division. However, there is no guarantee that a third party PMO can improve the performance of our current vendor.

Costs

The development costs of this solution are included in the original Xerox contract and will be absorbed by them. The additional cost for the PMO can be funded through a redirect request of approximately \$12 million dollars of current federal funding that was earmarked for Maintenance and Operations (M&O) costs to our current vendor Xerox that was based on 150,000 initial 2012 enrollment projections. Since enrollment is at around 35,000 today, \$10 million of this funding will never be utilized for that capacity. The Exchange has received preliminary estimates from multiple vendors to perform PMO services. They range from \$5 to \$10 million and cover a period from 6 to 12 months.

OPTION 1B: REMEDIATE BY OCTOBER 15, 2015 AND BECOME A SUPPORTED STATE BASED MARKETPLACE FOR PLAN YEAR 2015

Description

Similar to Option 1A, this would allow the Board to decide that Xerox would essentially take the next year to “fix” its system. The current Nevada Health Link portal would be maintained as the entry point for enrollment, with the federal eligibility and enrollment system as the operating platform. Xerox would continue the development of the current system, per the contract, over the next year, utilizing this time to fully test the system and implement the policies as provided by the Board, and be ready for open enrollment on October 15, 2015 (for plan year 2016), at no additional cost to Nevada.

Feasibility

The feasibility of this option correlates very close to the feasibility for Option 1A. Current contracts allow for the work and funding for Xerox to remediate its system. Providing another year for Xerox to solve issues may result in the system Nevada contracted for last October. The procurement process can still be utilized for a PMO and current funding is available.

Costs

Similar to Option 1A, the development costs of this solution are included in the original Xerox contract and will be absorbed by them. The additional cost for the PMO, as detailed above, can be funded through a redirect request of approximately \$10 million of previously awarded grant funds. This option will also include the cost of option 3.

OPTION 2: TRANSFER AN EXISTING SYSTEM FROM ANOTHER STATE

One of the options outlined in the Deloitte Assessment is to transfer a proven, functioning State Based Marketplace (SBM) from one of the states that was granted approval by CMS to build and operate a SBM. There are currently 8 states that have developed systems that allow more people per capita than Nevada to select and enroll in qualified health plans (Vermont, California, Rhode Island, Colorado, Connecticut, Washington, Kentucky, and New York). The process to transfer another state's system requires the appropriate time, funding, and oversight to ensure success. Additionally, if Nevada wants to utilize federal funding for this option, the federal government (CMS) would need to approve this process moving forward. An assessment of the Exchange's current capabilities and interconnectivity with Medicaid and the federal hub would need to be performed prior to any transferred system to determine the magnitude of changes needed to meet Nevada's laws, policies, and procedures.

OPTION 2A: TRANSFER THE CONNECTICUT SYSTEM BY NOVEMBER 15, 2014

Description

In the Deloitte assessment, Deloitte assessed Nevada's capabilities and utilized current knowledge of the Eligibility Engine (as they already are the contracted vendor) and its various interfaces to match up an existing system in another state for recommendation. Based on all the variables, Deloitte recommended the Connecticut Transfer System as it is a good strategic fit, satisfying business and functional requirements of the Exchange. The system comes complete with a single streamlined application that requires minimal modification, plan management functions, broker/assister portal, and carrier portal. It is setup to receive the same information from DOI as the current system for plan and rate uploading.

Feasibility

The Exchange can expedite the contract process and move forward quickly to begin implementation of the Connecticut transfer system. As with Option 1A, the transfer system would be required to meet specific benchmarks by June 30 or the opportunity to utilize the federal infrastructure will be lost. If the system has not met those requirements by June 30, the Exchange can utilize Option 2B below and utilize the federal eligibility and enrollment infrastructure in calendar year 2015 and become a Supported State Based Marketplace for plan year 2015 while continuing to develop the transfer system simultaneously for an October 15, 2015 launch (open enrollment for plan year 2016).

Costs

The cost of transferring in the Connecticut system is approximately \$67 million. Those costs include the system implementation, hardware and software for both pre-production and production environments, hosting of those environments, and any additional modifications required to modify the Connecticut system to Nevada. The \$67 million would come from federal grants: \$10 million redirected from current awards, and \$57 million requested at the next grant application.

OPTION 2B: TRANSFER SYSTEM BY OCTOBER 15, 2015 AND BECOME A SUPPORTED STATE BASED MARKETPLACE FOR PLAN YEAR 2015

Description

Similar to Option 2A, this would allow the Board to decide that the Exchange would utilize the federal infrastructure during the calendar year 2015 and become a Supported State Based Marketplace for plan year 2015 to take time to establish the transfer system of choice. Again, the current Nevada Health Link portal would be maintained as the entry point for enrollment, with the federal eligibility and enrollment system as the operating platform. The transfer vendor, procured through a transparent procurement would implement the transfer system making sure that it is ready for an October 15, 2015 rollout.

Feasibility

The Exchange can negotiate the costs for this option, and with this approach, an RFP would be released as soon as possible so that the vendors would have the most time available to establish the new system. This process would allow a competitive approach to choosing a new vendor which could drive costs down. Additionally, this approach allows for an opportunity to request any additional funding needed by the last available date of November 15, 2014.

Costs

The costs of this option are not readily available as the market has not determined the going rate for transfer system implementation in 2015. Current costs for an expedited transfer system range between \$40 - \$70 million. Again, the costs are relative to the amount of implementation and modification needed to meet Nevada's requirements. This option will also include the cost of option 3.

OPTION 3: UTILIZE THE FEDERAL INFRASTRUCTURE INDEFINITELY

Description

The Exchange may choose, much like Oregon is proposing, to utilize the federal infrastructure for eligibility and enrollment indefinitely. During the meeting with CMS, they indicated that at some future point, there may be a requirement for SBMs to take over the enrollment function; however, they would maintain the eligibility function for QHPs, APTC, and CSR indefinitely. This option would allow the state to maintain their SBM designation while adhering to the requirements of the ACA. The Exchange would maintain plan certification and management, Outreach and education as well as the ACA mandated navigator program. The federal infrastructure would include QHP call center customer service, appeals, exemptions; SHOP, and eligibility and enrollment for QHPs, APTC, and CSR.

Feasibility

This option is available for plan year 2015 immediately. CMS would need confirmation of this choice no later than June 30, 2014. Additionally, there are mandatory upgrades required to Nevada's Medicaid system to accept and transfer accounts to and from the federal infrastructure. The Exchange call center currently handles phone applications, and Medicaid would need to absorb this process to adhere to federal requirements. These two issues (upgrades and phone

applications) need to be developed further if the Exchange utilizes the federal infrastructure for eligibility and enrollment during any option or timeframe.

Costs

The costs to permanently utilize the federal infrastructure are all embedded in the costs to upgrade and maintain the Medicaid system. Although the Exchange would drastically reduce its costs, Medicaid would need to request funding which includes a general fund match (90% federal, 10% general fund match). Early high-level estimates indicate a cost of \$15 - \$20 million, plus ongoing costs associated with phone application personnel support.

OPTION 4: RECOMMEND TO THE NEVADA LEGISLATURE THAT NEVADA OFFICIALLY BECOMES A FEDERALLY FACILITATED MARKETPLACE

Description

Nevada has the opportunity to return the Exchange functionality completely to the federal government and be designated as a FFM. This option would require the Board to submit a Bill Draft Request to the Legislature recommending the disbandment of the Exchange, and the repealing of NRS 695I. All control and functionality, with exception of Medicaid/CHIP functions, plan certification and rate review would revert to the feds.

Feasibility

In order to activate this option, the Nevada Legislature would need to approve it during the 78th Legislative Session that begins February 2015. Therefore, this option would not provide short-term relief, and the Board would need to pursue the FFM infrastructure or continue ahead with Xerox during the interim to ensure Nevada continued to meet the ACA requirements.

Costs

Like all other options utilizing the federal infrastructure, the costs associated would be absorbed by Medicaid to again ensure that account transfers and phone applications could be performed in support of the federal eligibility and enrollment infrastructure. The costs associated with Medicaid upgrades would require state general fund match (90% federal, 10% general fund match) and high level estimates include \$15 - \$20 million plus ongoing application costs.

RECOMMENDATION

The Board selects an option above or explores new options to ensure the success of the Exchange.